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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KAYVAN DON HADDADAN, M.D.** **729 Sunrise Ave., Ste. 602** **Roseville, CA 95661-4542** **Physician's and Surgeon's Certificate No. A 87957,** Respondent.	Case No. 800-2019-053650 **A C C U S A T I O N**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 1, 2004, the Board issued Physician's and Surgeon's Certificate Number A 87957 to Kayvan Don Haddadan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2022, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
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> (d) Incompetence.
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> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
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> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:
>
> (a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.
>
> (b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.
>
> (c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTS

8. Respondent is a board-certified Physical Medicine and Rehabilitation physician. He owns and operates a pain management practice called Advanced Pain Diagnostic and Solutions. The practice has clinics in multiple locations throughout the greater Sacramento area. Respondent employs physicians and physician extenders who work in the practice with him.

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Patient 1

9. On or about April 1, 2013, Patient 1[1] began seeing Respondent for treatment of her chronic pain. Respondent conducted an initial evaluation of Patient 1 that included a comprehensive history and physical examination. Respondent conducted a review of systems and examination that included a musculoskeletal examination. Patient 1's past medical history was noted, including an assessment of pain, function, substance abuse history, past pain treatment, and the medical indication for the use of controlled substances. Specifically, Respondent noted that Patient 1 denied smoking, drinking alcohol, or any illicit drug use. Respondent documented that Patient 1 had prior medication treatment with Valium, Norco, and methadone. Patient 1 reported that the Norco was not as helpful as the methadone.

10. Respondent diagnosed Patient 1 with myofascial pain, multiple joint arthralgia, muscle spasm, and chronic pain syndrome. Respondent agreed to take over prescribing Patient 1's methadone and Valium prescriptions. Respondent prescribed a thirty-day supply of 120 tablets of methadone, 10 mg, with instructions to take two tablets in the morning and two at night. Goals of treatment were documented as well as informed consent. Patient 1 signed an opioid and controlled substances agreement.

11. Patient 1 saw Respondent each month at his practice, from the initial appointment through at least 2020, with limited exceptions. There were occasional appointments when Respondent's physician extenders, such as nurse practitioners or physician's assistants saw Patient 1. In each of these cases, Respondent reviewed and countersigned the notes. There were a few occasions when Patient 1 missed her monthly appointments, as for example between January and April of 2014, when Patient 1 had problems with her medical insurance.

12. As Respondent followed Patient 1 over the course of her years of treatment with him, there were occasions on which he altered her medication regimen to titrate up the methadone, or add a short-acting opioid for breakthrough pain, but by 2020 she was at the same daily morphine milligram equivalent (MME), that she began with in 2013, of 320 MME.

[1] The patient in this Accusation are referred to by number to protect their privacy.

13. During the course of Patient 1's treatment with Respondent, there were several significant events and medication changes which were noted periodically through the medical chart. On or about April 29, 2013, Patient 1's methadone prescription was titrated upward. At this appointment, Patient 1 told the provider that she had sought treatment in the emergency room for chronic obstructive pulmonary disorder (COPD).[2] Patient 1 was advised to stop smoking. Patient 1 indicated that she would follow-up with a psychiatrist and that the psychiatrist would assume responsibility for her Valium prescriptions. It does not appear as though this occurred immediately as Respondent continued to prescribe benzodiazepines to Patient 1 for several years.

14. On or about April 22, 2013, Respondent transitioned Patient 1 from Valium to Xanax for anxiety. On or about July 29, 2014, Patient 1 was switched to morphine immediate release for breakthrough pain. On or about August 26, 2014, Patient 1 reported the morphine had limited benefit and she was switched to Butrans. Patient 1 was involved in an accident in May of 2017, requiring treatment at the emergency room. This caused Patient 1 to have lower back pain.

15. On or about October 26, 2018, Patient 1 reported having pneumonia, which improved after a course of antibiotics. On or about January 6, 2020, Patient 1 was hospitalized for COPD. On or about May 12, 2020, Patient 1 was advised that she would be tapered down further from the methadone if there was no progress toward her treatment objectives.

16. Respondent instituted non-opioid treatment modalities including nortriptyline and lidocaine 5% ointment. Further, Patient 1 was offered nonsteroidal anti-inflammatory medications, but declined these. Further, she was recommended chiropractic care, home exercise programs, and heat and ice. She was also recommended aqua therapy, pain management procedures, acupuncture, and cognitive behavioral therapy.

17. Throughout Patient 1's course of treatment with Respondent, she had various diagnostic procedures completed. A knee x-ray was ordered on or about September 22, 2014, as well as a lumbar spine and bilateral knee imaging on or about March 16, 2020. Patient 1's EKG on or about May 12, 2016 was normal. Various Patient Health Questionnaires were completed in

[2] COPD is a chronic inflammatory lung disease that causes obstructed airflow from the lungs.

2019. On or about May 13, 2020, an MRI of the lumbar spine and bilateral knees was ordered. On or about December 30, 2020, a chest x-ray was completed.

18. Patient 1 had consultations with outside providers during her treatment with Respondent. On or about April 30, 2013, she noted that she was seeing a psychiatrist whom she would ask to take over prescribing her anxiety medications. On or about July 29, 2014, Patient 1 reported she was seeking a mental health provider for depression and anxiety that was currently managed by her primary care provider. In July of 2017, Patient 1 reported receiving relief of symptoms from her chiropractor. By May of 2019, Patient 1 reported that she was seeing a psychiatrist who was prescribing her Xanax with a plan to taper it down.

19. On or about February 10, 2015, Patient 1 had an appointment with Respondent, at which Respondent noted that Patient 1 tested negative for all controlled medications he was prescribing to her. Patient 1 claimed to have had pain from a recent dental appointment and used up all her prescribed medications early. Respondent documented that he would give Patient 1 the benefit of the doubt this time, but would require her to follow-up in two weeks. He renewed her prescription for the two weeks until she could return for another appointment and continued monitoring.

20. On or about May 14, 2015, Patient 1's urine drug test was positive for illicit methamphetamine. Respondent failed to address this aberrant test result with Patient 1 and document it in the progress notes, either at the May 2014 appointment, or any of the subsequent appointments he had with Patient 1. The next noted urine drug testing in Patient 1's chart is from September of 2015. The October 2015 progress notes state that the September test was consistent with the prescribed medications. At no point did Respondent refer Patient 1 to a specialist for treatment of addiction medicine.

Patient 2

21. Patient 2 began seeing Respondent in March of 2014, for treatment of knee and back pain. On or about March 20, 2014, Patient 2 had his initial evaluation with Respondent. At this appointment, Respondent documented a past medical and social history. Respondent noted that Patient 2 did not smoke, drink alcohol, or use recreational drugs. Respondent conducted a review

of systems and examination that included a review of systems and full examination, including a musculoskeletal examination. Respondent agreed to take over Patient 2's medications on this date.

22. At the next appointment, on or about May 1, 2014, Respondent diagnosed Patient 2 with displacement of thoracic or lumbar intervertebral disc, lower leg joint pain, and myalgia. Respondent prescribed Patient 2 methadone, 10 milligram tablets, three in the morning and four at night, for a total of 210 tablets every thirty days, Xanax; 1 milligram, three times per day, for a total of 90 tablets every 30 days, and Baclofen; 10 milligrams, one per day. At the next appointment, Respondent took over Patient 2's prescription of Soma, and added this to his medication regimen. Respondent documented treatment objectives, as well as informed consent. Patient 2 signed an opioid and controlled substances agreement. Respondent later also diagnosed Patient 2 with chronic pain syndrome, lumbar radiculopathy, and cervical radiculopathy.

23. As with Patient 1, Respondent usually saw Patient 2 each month at his practice, from the initial appointment through at least 2020, with limited exceptions. On occasion, Patient 2 would see Respondent more or less frequently than once per month, and on occasion, Respondent's physician extenders, such as nurse practitioners or physician's assistants saw Patient 2 instead of Respondent. In each of these cases, Respondent reviewed and countersigned the notes.

24. As Respondent followed Patient 2 over the course of his years of treatment with him, there were occasions on which he altered Patient 2's medication regimen. During 2015, Respondent tapered down Patient 2's Soma prescription and stopped it by the end of 2015. Throughout Patient 2's treatment, Respondent reduced his dose of Xanax. Respondent attempted to taper down Patient 2's methadone prescription several times during the treatment period, although there were times when the dose was increased for a time due to increased pain or anxiety. Over the course of treatment, however, the overall MME was decreased. For example, on or about May 4, 2014, the MME was 840 and by on or about September 18, 2019, it was 600. At no point during his treatment did Respondent ever order or document review of an EKG test for Patient 2, despite the continuing doses of methadone Patient 2 was taking.

25. On or about May 14, 2020, Respondent cautioned Patient 2 on the use of benzodiazepines with opioids and recommended Patient 2 follow-up with his primary care provider for treatment of his anxiety. Respondent had introduced non-controlled medications such as nortriptyline and Medrol. Other non-opioid pharmacologic treatments Respondent prescribed included baclofen, trazodone, indomethacin, methocarbamol, cyclobenzaprine, and ibuprofen.

26. Throughout the course of treatment, Respondent also recommended non-medication interventions for Patient 2. On or about June 20, 2018, Respondent performed a lumbar steroid facet joint injection. On or about November 5, 2018, Respondent performed a lumbar transforaminal epidural steroid injection and a carpometacarpal steroid injection on or about January 9, 2019. During March and April of 2019, he performed medial branch blocks. Respondent further recommended Patient 2 integrate heat, ice, and exercises into his self-care treatments at home.

27. Throughout the course of treatment, Respondent further ordered various imaging, including both plain x-rays, and MRIs of the spine and joints. On or about June 6, 2018, Respondent referred Patient 2 to a spine surgeon for evaluation. Patient 2 also reported he was being referred to a specialist for cancer screening.

28. On or about April 17, 2020 and April 24, 2020, Patient 2 reported to Respondent that he was having thoughts of harming himself due to the pain and anxiety of reducing his controlled medications. Respondent documented that Patient 2 did not have a plan formed to act out any suicidal ideation. Despite Patient 2's statements, Respondent failed to refer Patient 2 to mental health services.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

29. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that he was grossly negligent in his care and treatment of Patient 1.

30. Paragraphs 8 through 20, above, are incorporated herein as if fully set forth.

31. Respondent was grossly negligent for his acts and omissions in the care and treatment of Patient 1, by failing to note or address aberrant urine drug tests in Patient 1, including a test that was positive for illicit methamphetamine use in May of 2015.

32. Respondent's conduct, as set forth above, constitutes gross negligence in violation of section 2234, subdivision (b), of the Code, thus subjecting Respondent's license to discipline.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

33. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he was repeatedly negligent in his care and treatment of Patients 1 and 2. The circumstances are as follows:

34. Paragraphs 8 through 28, above, are incorporated herein as if fully set forth.

35. Respondent was repeatedly negligent for his acts and omissions, in his care and treatment of Patients 1 and 2, including, but not limited to, the following:

a. Failing to note or address aberrant urine drug tests in Patient 1, including a test that was positive for illicit methamphetamine use in May of 2015;

b. Failing to refer Patient 1 to an addiction medicine specialist following aberrant urine drug tests, including a test that was positive for illicit methamphetamine use in May of 2015;

c. Failing to refer Patient 2 to mental health services despite Patient 2's reports of thoughts of harming himself; and

d. Failing to order and EKG test for Patient 2 or note review of recent EKGs despite Patient 2's moderately high dose of methadone.

36. Respondent's conduct, as set forth above, constitutes repeated negligent acts in violation of subdivision 2234, subdivision, (c) of the Code, thus subjecting Respondent's license to discipline.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 87957, issued to Respondent Kayvan Don Haddadan, M.D.;

2. Revoking, suspending or denying approval of Respondent Kayvan Don Haddadan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Kayvan Don Haddadan, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: MAR 11 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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